Every Woman Matters

Nebraska Office of Women's Health

Provider Materials Reorder Form

2009

Fax: (402) 471-0913 *(all orders must be faxed)*

E-mail: every.woman.matters@nebraska.gov

Website: www.dhhs.ne.gov/womenshealth/ewm

Mail: Every Woman Matters
P.O. Box 94817
Lincoln, NE 68509-4817

Send Materials To: *(write clearly, use a stamp or tape your business card here)*

Facility: _____

Attention: _____

Mailing Address: _____

_____ Zip: _____

Phone: _____ Fax: _____

E-Mail: _____

Please allow 2 weeks for your order to be filled and shipped. Thank You!

BE SURE TO INDICATE THE QUANTITY OF MATERIALS YOU ARE REQUESTING.
DO NOT PLACE A CHECKMARK BY THE INDIVIDUAL ITEMS NEEDED.
NO MORE THAN 25 OF ANY ONE ITEM WILL BE SENT OUT AT ONE TIME.

Provider Materials

Provider Manual	_____
Presumptive Eligibility Enrollment form - *pink*	____ English ____ Spanish
Enrollment Packets *yellow forms for non-presumptive enrollment*	____ English ____ Spanish
Cervical Diagnostic Enrollment / Follow Up & Treatment Plan - *blue*	____ English ____ Spanish
Breast Diagnostic Enrollment / Follow Up & Treatment Plan - *goldenrod*	____ English ____ Spanish
EWM Mammography Reporting form	_____
Lab stickers - 50 stickers per sheet *red & white*	_____ *sheets*
Report of Woman Deemed Lost-to-Follow Up form	_____
Client Informed Refusal form	_____
Treatment Funds Request Form	_____
Pre-addressed labels to Every Woman Matters - 30 stickers per sheet	_____*sheets*
Eligibility Scale	_____

Promotional Items

Every Woman Matters program brochures *(English/Spanish printed together)*	_____
Helping Women Live Healthier Lives Materials:	
Table tents	____ African American ____ Spanish ____ Diverse
8 1/2 x 11 display poster	____ African American ____ Spanish ____ Diverse
11 x 17 display poster	____ African American ____ Spanish ____ Diverse

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Presumptive Eligibility Enrollment Form (pink)

- 14x25 (6 page tri fold)
- Page 1 - Enrollment & Health Assessment
- Page 2 - Health Assessment (continued)
- Page 3 - Documents the client's screening visit
- Page 4/5 - Heart Health Screening Results (tear out for client)
- Page 6 - Informed Consent
- Purpose: Used in the clinic to enroll a woman and document the screening visit

Client completes

Presumptive Eligibility Enrollment Form for Women 40-64

Every Woman Matters

Please write clearly. Shaded boxes must be filled in and page 6 must be signed. Fill in as much of the rest of this page as you can.

#1-Version: August 2008 (pink)

(800) 532-2227

Reasonable accommodations made for persons with disabilities. TDD (800) 833-7352.

First Name	Initial	Last Name	Maiden Name
Birthdate / /	Age	Social Security #	
Address	City	County	State / Zip
Home/Cell Phone ( )	Work Phone ( )	How did you hear about Every Woman Matters? ☐ Health Fair ☐ Doctor clinic ☐ Agency ☐ self-referral ☐ other ☐ newspaper/radio/TV ☐ outreach worker	
Contact person. In case we can't reach you	Relationship	Phone-Home / Work / Cell circle one ( )	
Address	City	State / Zip	

What race or ethnicity are you?
☐ American Indian Tribe ☐ Black/African American ☐ White ☐ Pacific Islander ☐ Mexican American ☐ Asian ☐ Other

Are you of Hispanic/Latina origin? ☐ Yes ☐ No
Country of origin
What is your primary language?
☐ English ☐ Spanish ☐ Vietnamese ☐ Other

Highest grade in school you completed: circle one 0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16+

Have you ever had these exams in the past? If you do not know exact date, give your best guess.
Pap test ☐ No ☐ Yes Date last exam __/__/__ Results: ☐ Normal ☐ Abnormal
What did your doctor say about your exam?
Mammogram ☐ No ☐ Yes Date last exam __/__/__ Results: ☐ Normal ☐ Abnormal
What did your doctor say about your exam?

Has your mother, sister or daughter ever had breast cancer? ☐ No ☐ Yes ☐ Don't Know
Have you ever had breast cancer ☐ No ☐ Yes ☐ Don't Know
Have you ever had a hysterectomy (removal of the uterus)? ☐ No ☐ Yes ☐ Don't Know
If you have had a hysterectomy, was it to take care of cancer? ☐ No ☐ Yes ☐ Don't Know

I will be required to show proof that my income is within the EWM income guidelines when I am contacted by EWM's program staff. If I am found to be over the income guidelines, I will be responsible for my bills.

What is your household income before taxes? $
How many people live on this income?
Yearly Income:

Do you have: ☐ Medicare Part A only ☐ Medicare Part A and B ☐ None/No Coverage ☐ Medicaid (full coverage for self) ☐ Private Insurance with or without Medicaid Supplement (please list)

Is your insurance an HMO? ☐ Yes ☐ No An HMO is a health maintenance organization.
If you have Medicaid for yourself or your insurance is an HMO, you may not enroll in Every Woman Matters.

Mailing Address: Every Woman Matters-301 Centennial Mall South, P.O. Box 94817, Lincoln, NE 68509-4817

Health Assessment

Please answer the questions below before you see your healthcare provider. Your response helps us and our partners select a plan for future programs, education, and information related to good health.

Have you ever been told by a doctor, nurse, or other health professional that your blood cholesterol is high? ☐ Yes ☐ No ☐ Don't Know ☐ Don't want to answer

Have you ever been told by a doctor, nurse, or other health professional that you have high blood pressure? ☐ Yes ☐ No ☐ Don't Know ☐ Don't want to answer

Have you ever been told by a doctor, nurse, or other health professional that you have diabetes? ☐ Yes ☐ No ☐ Don't Know ☐ Don't want to answer

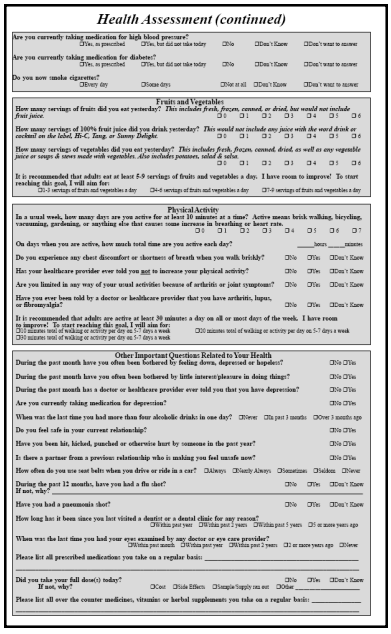
Has a doctor, nurse, or other health professional ever told you that you had any of the following: heart attack (also called myocardial infarction), angina, coronary heart disease, or stroke? ☐ Yes ☐ No ☐ Don't Know ☐ Don't want to answer

Has your father, brother, or son had a stroke or heart attack before age 65? ☐ Yes ☐ No ☐ Don't Know ☐ Don't want to answer

Has your mother, sister, or daughter had a stroke or heart attack before age 65? ☐ Yes ☐ No ☐ Don't Know ☐ Don't want to answer

Has either of your parents, your brother or sister, or your child ever been told by a doctor, nurse, or other health professional that he or she has diabetes? ☐ Yes ☐ No ☐ Don't Know ☐ Don't want to answer

Are you currently taking medication for high cholesterol? ☐ Yes, as prescribed ☐ Yes, but did not take today ☐ No ☐ Don't Know ☐ Don't want to answer



Health Assessment (continued)

Are you currently taking medication for high blood pressure? ☐ Yes, as prescribed ☐ Yes, but did not take today ☐ No ☐ Don't Know ☐ Don't want to answer

Are you currently taking medication for diabetes? ☐ Yes, as prescribed ☐ Yes, but did not take today ☐ No ☐ Don't Know ☐ Don't want to answer

Do you now smoke cigarettes? ☐ Every day ☐ Some days ☐ Not at all ☐ Don't Know ☐ Don't want to answer

Fruits and Vegetables

How many servings of fruits did you eat yesterday? *This includes fresh, frozen, canned, or dried, but would not include fruit juice.* ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6

How many servings of 100% fruit juice did you drink yesterday? *This would not include any juice with the word drink or cocktail on the label, Hi-C, Tang, or Sunny Delight.* ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6

How many servings of vegetables did you eat yesterday? *This includes fresh, frozen, canned, dried, as well as any vegetable juice or soups & stews made with vegetables. Also includes potatoes, salad & salsa.* ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6

It is recommended that adults eat at least 5-9 servings of fruits and vegetables a day. I have room to improve! To start reaching this goal, I will aim for:
☐2-3 servings of fruits and vegetables a day ☐4-5 servings of fruits and vegetables a day ☐7-9 servings of fruits and vegetables a day

Physical Activity

In a usual week, how many days are you active for at least 10 minutes at a time? Active means brisk walking, bicycling, vacuuming, gardening, or anything else that causes some increase in breathing or heart rate. ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7

On days when you are active, how much total time are you active each day? _____hours _____minutes

Do you experience any chest discomfort or shortness of breath when you walk briskly? ☐No ☐Yes ☐Don't Know

Has your healthcare provider ever told you not to increase your physical activity? ☐No ☐Yes ☐Don't Know

Are you limited in any way of your usual activities because of arthritis or joint symptoms? ☐No ☐Yes ☐Don't Know

Have you ever been told by a doctor or healthcare provider that you have arthritis, lupus, or fibromyalgia? ☐No ☐Yes ☐Don't Know

It is recommended that adults are active at least 30 minutes a day on all or most days of the week. I have room to improve! To start reaching this goal, I will aim for:
☐30 minutes total of walking or activity per day on 5-7 days a week ☐60 minutes total of walking or activity per day on 5-7 days a week
☐90 minutes total of walking or activity per day on 5-7 days a week

Other Important Questions Related to Your Health

During the past month have you often been bothered by feeling down, depressed or hopeless? ☐No ☐Yes

During the past month have you often been bothered by little interest/pleasure in doing things? ☐No ☐Yes

During the past month has a doctor or healthcare provider ever told you that you have depression? ☐No ☐Yes

Are you currently taking medication for depression? ☐No ☐Yes

When was the last time you had more than four alcoholic drinks in one day? ☐Never ☐In past 3 months ☐Over 3 months ago

Do you feel safe in your current relationship? ☐No ☐Yes

Have you been hit, kicked, punched or otherwise hurt by someone in the past year? ☐No ☐Yes

Is there a partner from a previous relationship who is making you feel unsafe now? ☐No ☐Yes

How often do you use seat belts when you drive or ride in a car? ☐Always ☐Nearly Always ☐Sometimes ☐Seldom ☐Never

During the past 12 months, have you had a flu shot? If not, why? ☐No ☐Yes ☐Don't Know

Have you had a pneumonia shot? ☐No ☐Yes ☐Don't Know

How long has it been since you last visited a dentist or a dental clinic for any reason? ☐Within past year ☐Within past 2 years ☐Within past 5 years ☐5 or more years ago

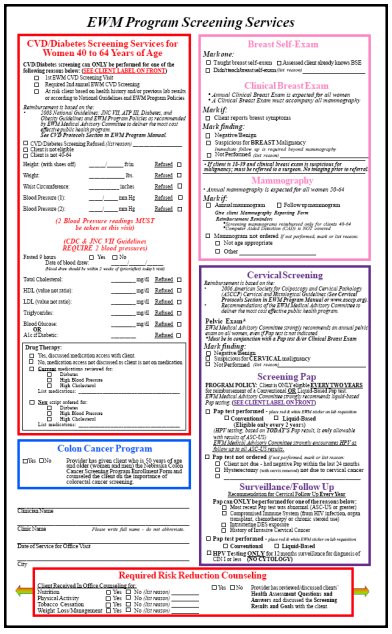
When was the last time you had your eyes examined by any doctor or eye care provider? ☐Within past month ☐Within past year ☐Within past 2 years ☐2 or more years ago ☐Never

Please list all prescribed medications you take on a regular basis: _____

Did you take your full dose(s) today? If not, why? ☐No ☐Yes ☐Don't Know ☐Out ☐Side Effects ☐Ineffective ☐Supply ran out ☐Other

Please list all over the counter medicines, vitamins or herbal supplements you take on a regular basis: _____

Provider completes



EWM Program Screening Services

CVD/Diabetes Screening Services for Women 40 to 64 Years of Age

CVD/Diabetes screening can ONLY be performed for one of the following reasons below: (SEE CLIENT LABEL ON FRONT)
☐ 1st EWM CVD Screening Visit
☐ Required 2nd annual EWM CVD Screening
☐ At-risk client based on health history and/or previous lab results or according to National Guidelines and EWM Program Policies

Reimbursement is based on the:
- *2006 National Guidelines: JNC VII, ATP III Guidance, and ADA Standards of Medical Care in Diabetes 2006 as recommended by EWM Medical Advisory Committee to deliver the most cost effective public health program*
- *See CVD Protocols Section in EWM Program Manual.*

☐ CVD/Diabetes Screening Refused (list reasons) _____
☐ Client is not eligible
☐ Client is not 40-64

Height: (with shoes off)	_____/_____ ft/in	Refused ☐
Weight:	_____ lbs	Refused ☐
Waist Circumference:	_____ inches	Refused ☐
Blood Pressure (1):	_____/_____ mm Hg	Refused ☐
Blood Pressure (2):	_____/_____ mm Hg	Refused ☐

(2 Blood Pressure readings MUST be taken at this visit)

(JNC 6, JNC VII Guidelines REQUIRE 2 blood pressures)

Fasted 8 hours ☐ Yes ☐ No
Date of blood draw: _____
Blood draw should be within 2 weeks of prescribed client visit

Total Cholesterol:	_____ mg/dl	Refused ☐
HDL (value not mtn):	_____ mg/dl	Refused ☐
LDL (value not mtn):	_____ mg/dl	Refused ☐
Triglycerides:	_____ mg/dl	Refused ☐
Blood Glucose:	_____ mg/dl	Refused ☐
A1c (Diabetes):	_____	Refused ☐

Drug Therapy:
☐ Yes, discussed medication access with client.
☐ No, medication access not discussed as client is not on medications.
☐ Current medications reviewed for:
☐ Diabetes
☐ High Blood Pressure
☐ High Cholesterol
List medications: _____
☐ Non compliant
☐ Diabetes
☐ High Blood Pressure
☐ High Cholesterol
List medications: _____

Colon Cancer Program

☐ Yes ☐ No Provider has given client who is 50 years of age and older (women and men) the Nebraska Colon Cancer Screening Program Enrollment Form and counseled the client on the importance of colorectal cancer screening.

Clinic Site Name _____
Client Name _____ *Please write full name - do not abbreviate.*
Date of Service for Office Visit _____
City _____

Required Risk Reduction Counseling

Client Received In Office Counseling for: ☐ No ☐ Yes Provider has reviewed discussed client's Health Assessment Questions and Answers and discussed the Screening Results and Goals with the client.

Nutrition	☐ Yes ☐ No (list reasons)	_____
Physical Activity	☐ Yes ☐ No (list reasons)	_____
Tobacco Cessation	☐ Yes ☐ No (list reasons)	_____
Weight Loss Management	☐ Yes ☐ No (list reasons)	_____

Breast Self-Exam

Mark one:
☐ Taught breast self-exam ☐ Assessed client already knows BSE
☐ Did not teach/assess self-exam (list reasons) _____

Clinical Breast Exam

- *Annual Clinical Breast Exam is expected for all women*
- *A Clinical Breast Exam must accompany all mammography*

Mark if:
☐ Client reports breast symptoms

Mark finding:
☐ Negative/Benign
☐ Suspicious for BREAST Malignancy
Immediate follow up is required beyond mammography
☐ Not Performed (list reasons) _____

If client is 18-39 and Clinical breast exam is suspicious for malignancy, must be referred to a surgeon. No imaging prior to referral.

Mammography

- *Annual mammography is expected for all women 50-64*

Mark if:
☐ Ordered mammogram ☐ Follow up mammogram
One client Mammography Reporting Form
Reimbursement Reminders
- *Screening mammograms reimbursed only for clients 40-64*
- *Diagnostic mammograms reimbursed for all ages*

☐ Mammogram not ordered. If not performed, mark or list reasons:
☐ Not age appropriate
☐ Other _____

CervicalScreening

Reimbursement is based on the:
- *2006 American Society for Colposcopy and Cervical Pathology Consensus Guidelines, and Nebraska Guidelines (See Cervical Protocols Section in EWM Program Manual or www.asccp.org). Recommendations of the EWM Medical Advisory Committee to deliver the most cost effective public health program.*

Pelvic Exam*
EWM Medical Advisory Committee strongly recommends an annual pelvic exam on all women, even if Pap test is not indicated.
Must be in conjunction with a Pap test or for Clinical Breast Exam

Mark finding:
☐ Negative/Benign
☐ Suspicion for CERVICAL malignancy
☐ Not Performed (list reasons) _____

Screening Pap

PROGRAM POLICY: Client is ONLY eligible EVERY TWO YEARS for reimbursement of a Conventional OR Liquid-Based Pap test. *EWM Medical Advisory Committee strongly recommends liquid-based Pap testing* (SEE CLIENT LABEL ON FRONT)

☐ Pap test performed - *please mark when EWM sticker on lab requisition*
☐ Conventional ☐ Liquid-Based
(Eligible only every 2 years)
HPV testing, based on TODAY'S Pap result, is only allowable with results of ASC-US
EWM Medical Advisory Committee strongly encourages HPV to follow up on ALL ASC-US results.

☐ Pap test not ordered. If test performed, mark or list reasons:
☐ Client not due - had negative Pap within the last 24 months
☐ Hysterectomy (with cervix removed) not due to cervical cancer
☐ _____

Surveillance/Follow Up

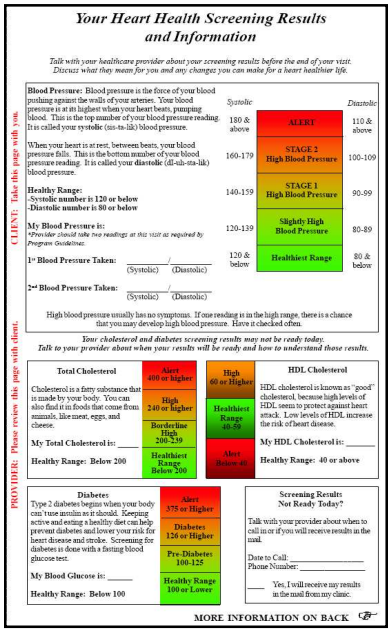
Recommendations for Cervical Follow Up Every Year

Pap (ONLY) be performed for one of the reasons below:
☐ Most recent Pap test was abnormal (ASC-US or greater)
☐ Compromised Immune System (from HIV infection, organ transplant, chemotherapy or chronic steroid use)
☐ Pregnant at this visit
☐ History of Invasive Cervical Cancer

☐ Pap test performed - *please mark when EWM sticker on lab requisition*
☐ Conventional ☐ Liquid-Based

☐ HPV Testing ONLY for Unknown surveillance for diagnosis of CIN 1 or less - (NOT ETOLOGY)

Provider and Client completes together



Your Heart Health Screening Results and Information

Talk with your healthcare provider about your screening results before the end of your visit. Discuss what they mean for you and any changes you can make for a heart healthier life.

CLIENT: Take this page with you.

Blood Pressure: Blood pressure is the force of your blood pushing against the walls of your arteries. Your blood pressure is at its highest when your heart beats, pumping blood. This is the top number of your blood pressure reading. It is called your **systolic** (sis-ta-lik) blood pressure.

When your heart is at rest, between beats, your blood pressure falls. This is the bottom number of your blood pressure reading. It is called your **diastolic** (dil-uh-sta-lik) blood pressure.

Healthy Range:
-**Systolic number is 120 or below**
-**Diastolic number is 80 or below**

My Blood Pressure is:
**Provider should take two readings at this visit as required by Program Guidelines:*

1st **Blood Pressure Taken:** _____/_____ (Systolic) (Diastolic)

2nd **Blood Pressure Taken:** _____/_____ (Systolic) (Diastolic)

Systolic		Diastolic
180 & above	ALERT	110 & above
160-179	STAGE 2 High Blood Pressure	100-109
140-159	STAGE 1 High Blood Pressure	90-99
120-139	Slightly High Blood Pressure	80-89
120 & below	Healthiest Range	80 & below

High blood pressure usually has no symptoms. If one reading is in the high range, there is a chance that you may develop high blood pressure. Have it checked often.

Your cholesterol and diabetes screening results may not be ready today. Talk to your provider about when your results will be ready and how to understand those results.

Total Cholesterol

Cholesterol is a fatty substance that is made by your body. You can also find it in foods that come from animals, like meat, eggs, and cheese.

My Total Cholesterol is: _____

Healthy Range: Below 200

Alert	400 or higher
High	240 or higher
Borderline High	200-239
Healthiest Range	Below 200

HDL Cholesterol

HDL cholesterol is known as "good" cholesterol, because high levels of HDL seem to protect against heart attack. Low levels of HDL increase the risk of heart disease.

My HDL Cholesterol is: _____

Healthy Range: 40 or above

High	60 or Higher
Healthiest Range	40-59
Alert	Below 40

Diabetes

Type 2 diabetes begins when your body can't use insulin as it should. Keeping active and eating a healthy diet can help prevent diabetes and lower your risk for heart disease and stroke. Screening for diabetes is done with a fasting blood glucose test.

My Blood Glucose is: _____

Healthy Range: Below 100

Alert	375 or Higher
Diabetes	126 or Higher
Pre-Diabetes	100-125
Healthy Range	100 or Lower

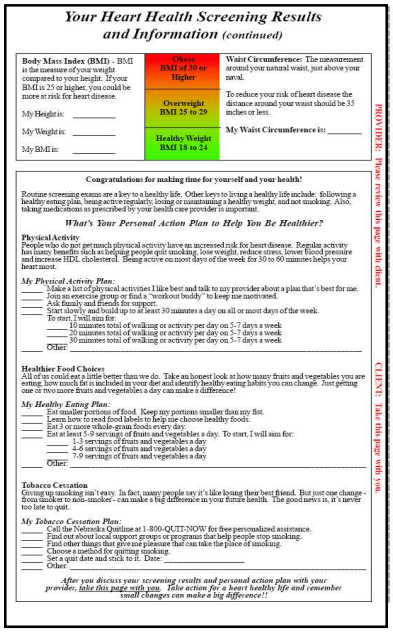
Screening Results Not Ready Today?

Talk with your provider about when to call in or if you will receive results in the mail.

Date to Call: _____
Phone Number: _____

___ Yes, I will receive my results in the mail from my clinic.

MORE INFORMATION ON BACK



Your Heart Health Screening Results and Information (continued)

PROVIDER: Please review this page with client.

Body Mass Index (BMI) - BMI is the measure of your weight compared to your height. If your BMI is 25 or higher, you could be more at risk for heart disease.

My Height is: _____
My Weight is: _____
My BMI is: _____

Obese	BMI of 30 or Higher
Overweight	BMI 25 to 29
Healthy Weight	BMI 18 to 24

Waist Circumference: The measurement around your natural waist, just above your naval.

To reduce your risk of heart disease the distance around your waist should be 35 inches or less.

My Waist Circumference is: _____

Congratulations for making time for yourself and your health!

Routine screening exams are a key to a healthy life. Other keys to living a healthy life include: following a healthy eating plan, being active regularly, losing or maintaining a healthy weight, and not smoking. Also, taking medications as prescribed by your health care provider is important.

What's Your Personal Action Plan to Help You Be Healthier?

Physical Activity
People who do not get much physical activity have an increased risk for heart disease. Regular activity has many benefits such as helping people quit smoking, lose weight, reduce stress, lower blood pressure and increase HDL cholesterol. Being active on most days of the week for 30 to 60 minutes helps your heart most.

My Physical Activity Plan:
_____ Make a list of physical activities I like best and talk to my provider about a plan that's best for me.
_____ Join an exercise group or find a "workout buddy" to keep me motivated.
_____ Ask family and friends for support.
_____ Start slowly and build up to at least 30 minutes a day on all or most days of the week.
To start, I will aim for:
_____ 10 minutes total of walking or activity per day on 5-7 days a week
_____ 20 minutes total of walking or activity per day on 5-7 days a week
_____ 30 minutes total of walking or activity per day on 5-7 days a week
_____ Other: _____

Healthier Food Choices
All of us could eat a little better than we do. Take an honest look at how many fruits and vegetables you are eating, how much fat is included in your diet and identify healthy eating habits you can change. Just getting one or two more fruits and vegetables a day can make a difference!

My Healthy Eating Plan:
_____ Eat smaller portions of food. Keep my portions smaller than my fist.
_____ Learn how to read food labels to help me choose healthy foods.
_____ Eat 3 or more whole-grain foods every day.
_____ Eat at least 5-9 servings of fruits and vegetables a day. To start, I will aim for:
_____ 1-3 servings of fruits and vegetables a day
_____ 4-6 servings of fruits and vegetables a day
_____ 7-9 servings of fruits and vegetables a day
_____ Other: _____

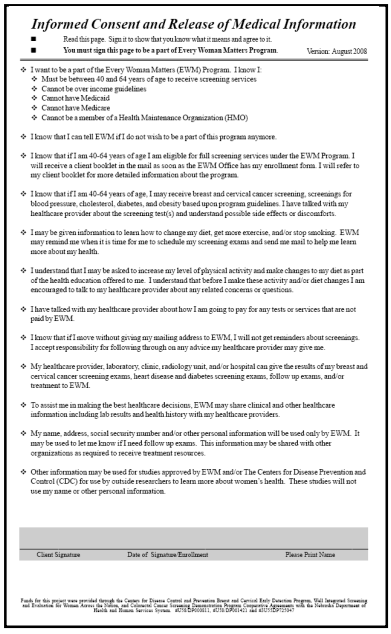
Tobacco Cessation
Giving up smoking isn't easy. In fact, many people say it's like losing their best friend. But just one change - from smoker to non-smoker - can make a big difference in your future health. The good news is, it's never too late to quit.

My Tobacco Cessation Plan:
_____ Call the Nebraska Quitline at 1-800-QUIT-NOW for free personalized assistance.
_____ Find out about local support groups or programs that help people stop smoking.
_____ Find other things that give me pleasure that can take the place of smoking.
_____ Choose a method for quitting smoking.
_____ Set a quit date and stick to it. Date: _____
_____ Other: _____

After you discuss your screening results and personal action plan with your provider, take this page with you. Take action for a heart healthy life and remember small changes can make a big difference!!

CLIENT: Take this page with you.

Client completes



Informed Consent and Release of Medical Information

- Read this page. Sign it to show that you know what it means and agree to it.
- **You must sign this page to be a part of Every Woman Matters Program.** Version: August 2008

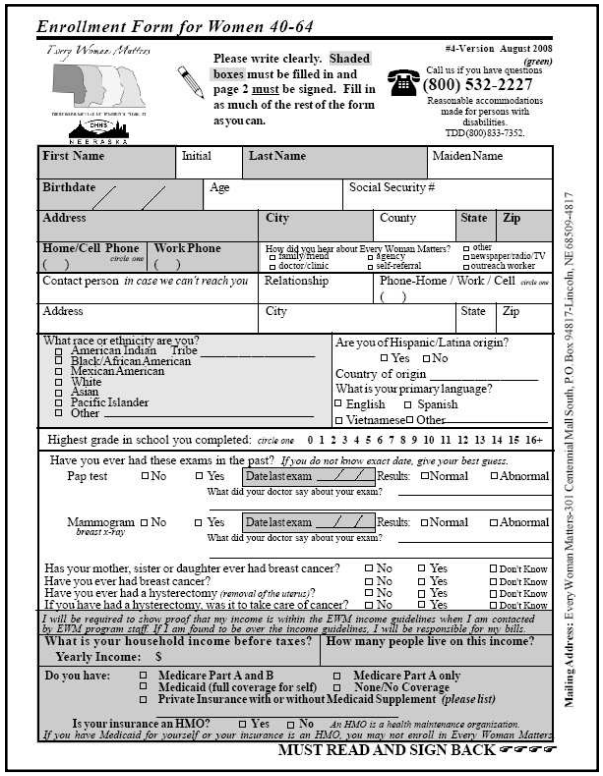
- I want to be a part of the Every Woman Matters (EWM) Program. I know I:
  - Must be between 40 and 64 years of age to receive screening services
  - Cannot be over income guidelines
  - Cannot have Medicaid
  - Cannot have Medicare
  - Cannot be a member of a Health Maintenance Organization (HMO)
- I know that I can tell EWM if I do not wish to be a part of this program anymore.
- I know that if I am 40-64 years of age I am eligible for full screening services under the EWM Program. I will receive a client booklet in the mail as soon as the EWM Office has my enrollment form. I will refer to my client booklet for more detailed information about the program.
- I know that if I am 40-64 years of age, I may receive breast and cervical cancer screening, screenings for blood pressure, cholesterol, diabetes, and obesity based upon program guidelines. I have talked with my healthcare provider about the screening test(s) and understand possible side effects or discomforts.
- I may be given information to learn how to change my diet, get more exercise, and/or stop smoking. EWM may remind me when it is time for me to schedule my screening exams and send me mail to help me learn more about my health.
- I understand that I may be asked to increase my level of physical activity and make changes to my diet as part of the health education offered to me. I understand that before I make these activity and/or diet changes I am encouraged to talk to my healthcare provider about any related concerns or questions.
- I have talked with my healthcare provider about how I am going to pay for any tests or services that are not paid by EWM.
- I know that if I move without giving my mailing address to EWM, I will not get reminders about screenings. I accept responsibility for following through on any advice my healthcare provider may give me.
- My healthcare provider, laboratory, clinic, radiology unit, and/or hospital can give the results of my breast and cervical cancer screening exams, heart disease and diabetes screening exams, follow up exams, and/or treatment to EWM.
- To assist me in making the best healthcare decisions, EWM may share clinical and other healthcare information including lab results and health history with my healthcare providers.
- My name, address, social security number and/or other personal information will be used only by EWM. It may be used to let me know if I need follow up exams. This information may be shared with other organizations as required to receive treatment resources.
- Other information may be used for studies approved by EWM and/or The Centers for Disease Prevention and Control (CDC) for use by outside researchers to learn more about women's health. These studies will not use my name or other personal information.

Client Signature	Date of Signature/Enrollment	Please Print Name

Funds for this project were provided through the Centers for Disease Control and Prevention Breast and Cervical Early Detection Program, Full Integrated Screening and Evaluation for Women Across the Nation, and Colorectal Cancer Screening Demonstration Program Cooperative Agreements with the Nebraska Department of Health and Human Services System. #U58/DP000811, #U58/DP001421 and #U55/DP925067

Enrollment Form (40+) (yellow)

- 8 1/2 x 11 (2 pages)
- Page 1 - Enrollment
- Page 2 - Informed Consent
- Purpose: Used to enroll women 40 through 64 (give client enrollment in office to take home to fill out and send in)



Enrollment Form for Women 40-64

Every Woman Matters

#4-Version August 2008 *(green)*

Please write clearly. Shaded boxes must be filled in and page 2 must be signed. Fill in as much of the rest of the form as you can.

Call us if you have questions **(800) 532-2227**

Reasonable accommodations made for persons with disabilities. TDD(800)833-7352.

First Name	Initial	Last Name	Maiden Name
Birthdate / /	Age	Social Security #	

Address	City	County	State	Zip
Home/Cell Phone ( ) *circle one*	Work Phone ( )	How did you hear about Every Woman Matters? ☐ family/friend ☐ doctor/clinic ☐ Agency ☐ self-referral ☐ other ☐ newspaper/radio/TV ☐ outreach worker		
Contact person *in case we can't reach you*	Relationship	Phone-Home / Work / Cell *circle one* ( )		
Address	City	State	Zip	

What race or ethnicity are you?
☐ American Indian Tribe _____
☐ Black/African American
☐ Mexican American
☐ White
☐ Asian
☐ Pacific Islander
☐ Other _____

Are you of Hispanic/Latina origin? ☐ Yes ☐ No

Country of origin _____

What is your primary language? ☐ English ☐ Spanish ☐ Vietnamese ☐ Other _____

Highest grade in school you completed: *circle one* 0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16+

Have you ever had these exams in the past? *If you do not know exact date, give your best guess.*

Pap test ☐ No ☐ Yes Date last exam ___/___/___ Results: ☐ Normal ☐ Abnormal
What did your doctor say about your exam? _____

Mammogram *breast x-ray* ☐ No ☐ Yes Date last exam ___/___/___ Results: ☐ Normal ☐ Abnormal
What did your doctor say about your exam? _____

Has your mother, sister or daughter ever had breast cancer?	☐ No	☐ Yes	☐ Don't Know
Have you ever had breast cancer?	☐ No	☐ Yes	☐ Don't Know
Have you ever had a hysterectomy *(removal of the uterus)*?	☐ No	☐ Yes	☐ Don't Know
If you have had a hysterectomy, was it to take care of cancer?	☐ No	☐ Yes	☐ Don't Know

I will be required to show proof that my income is within the EWM income guidelines when I am contacted by EWM program staff. If I am found to be over the income guidelines, I will be responsible for my bills.

What is your household income before taxes? **How many people live on this income?**

Yearly Income: $

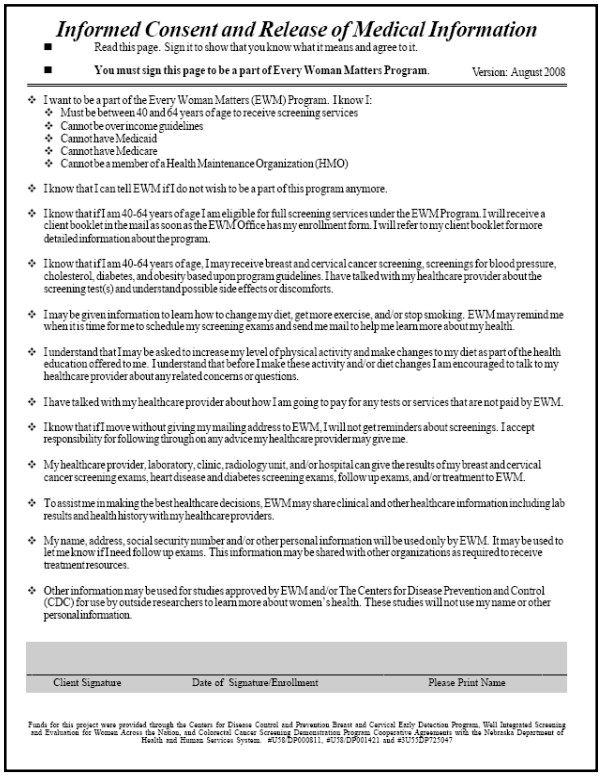
Do you have:
☐ **Medicare Part A and B** ☐ **Medicare Part A only**
☐ **Medicaid (full coverage for self)** ☐ **None/No Coverage**
☐ **Private Insurance with or without Medicaid Supplement** *(please list)*
_____

Is your insurance an HMO? ☐ **Yes** ☐ **No** *An HMO is a health maintenance organization. If you have Medicaid for yourself or your insurance is an HMO, you may not enroll in Every Woman Matters.*

MUST READ AND SIGN BACK

Mailing Address: Every Woman Matters-301 Centennial Mall South, P.O. Box 94817-Lincoln, NE 68509-4817

Client completes



Informed Consent and Release of Medical Information

- Read this page. Sign it to show that you know what it means and agree to it.
- **You must sign this page to be a part of Every Woman Matters Program.**

Version: August 2008

- I want to be a part of the Every Woman Matters (EWM) Program. I know I:
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  - Cannot be over income guidelines
  - Cannot have Medicaid
  - Cannot have Medicare
  - Cannot be a member of a Health Maintenance Organization (HMO)
- I know that I can tell EWM if I do not wish to be a part of this program anymore.
- I know that if I am 40-64 years of age I am eligible for full screening services under the EWM Program. I will receive a client booklet in the mail as soon as the EWM Office has my enrollment form. I will refer to my client booklet for more detailed information about the program.
- I know that if I am 40-64 years of age, I may receive breast and cervical cancer screening, screenings for blood pressure, cholesterol, diabetes, and obesity based upon program guidelines. I have talked with my healthcare provider about the screening test(s) and understand possible side effects or discomforts.
- I may be given information to learn how to change my diet, get more exercise, and/or stop smoking. EWM may remind me when it is time for me to schedule my screening exams and send me mail to help me learn more about my health.
- I understand that I may be asked to increase my level of physical activity and make changes to my diet as part of the health education offered to me. I understand that before I make these activity and/or diet changes I am encouraged to talk to my healthcare provider about any related concerns or questions.
- I have talked with my healthcare provider about how I am going to pay for any tests or services that are not paid by EWM.
- I know that if I move without giving my mailing address to EWM, I will not get reminders about screenings. I accept responsibility for following through on any advice my healthcare provider may give me.
- My healthcare provider, laboratory, clinic, radiology unit, and/or hospital can give the results of my breast and cervical cancer screening exams, heart disease and diabetes screening exams, follow up exams, and/or treatment to EWM.
- To assist me in making the best healthcare decisions, EWM may share clinical and other healthcare information including lab results and health history with my healthcare providers.
- My name, address, social security number and/or other personal information will be used only by EWM. It may be used to let me know if I need follow up exams. This information may be shared with other organizations as required to receive treatment resources.
- Other information may be used for studies approved by EWM and/or The Centers for Disease Prevention and Control (CDC) for use by outside researchers to learn more about women's health. These studies will not use my name or other personal information.

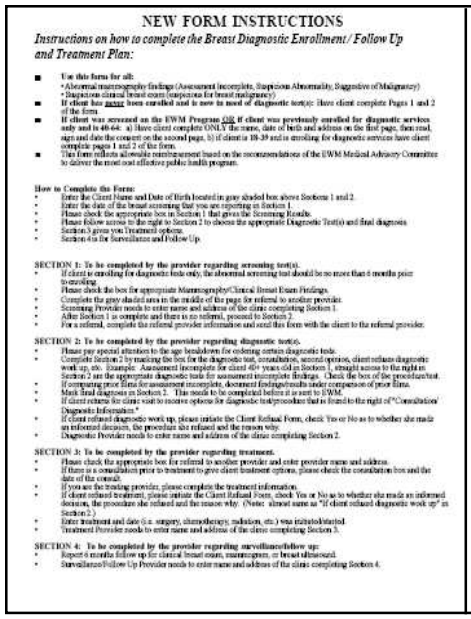
Client Signature | Date of Signature/Enrollment | Please Print Name

Funds for this project were provided through the Centers for Disease Control and Prevention Breast and Cervical Early Detection Program, Well Integrated Screening and Evaluation for Women Across the Nation, and Colorectal Cancer Screening Demonstration Program Cooperative Agreements with the Nebraska Department of Health and Human Services System. #U58/DP000811, #U58/DP001421 and #3U55DP725947

Client completes

Breast Diagnostic Enrollment/Follow Up and Treatment Form (goldenrod)

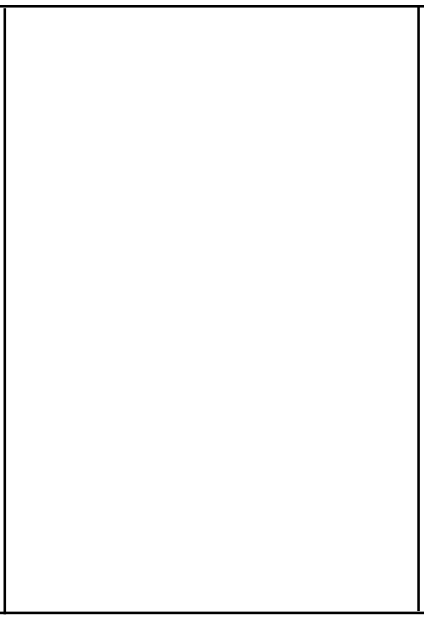
- 11x25 (6 page fold out)
- Page 1 - Enrollment
- Page 2 - Informed Consent
- Page 3/4 - Documents the client's medical necessity for services
- Page 5 - Instructions for Clinic on how to use the form
- Purpose: 1. Used in the clinic to enroll a client when there is a need of diagnostic services after an abnormal breast screening and to document short interval breast exam, mammogram order or consultation
  2. Completed after an abnormal screening mammogram. Used when performing diagnostic procedures and treatment and/or referring for further evaluation, diagnostic procedures, or treatment. Also used to report on a diagnostic mammogram and breast ultrasound.



NEW FORM INSTRUCTIONS

Instructions on how to complete the Breast Diagnostic Enrollment/ Follow Up and Treatment Plan:

Provider Instructions



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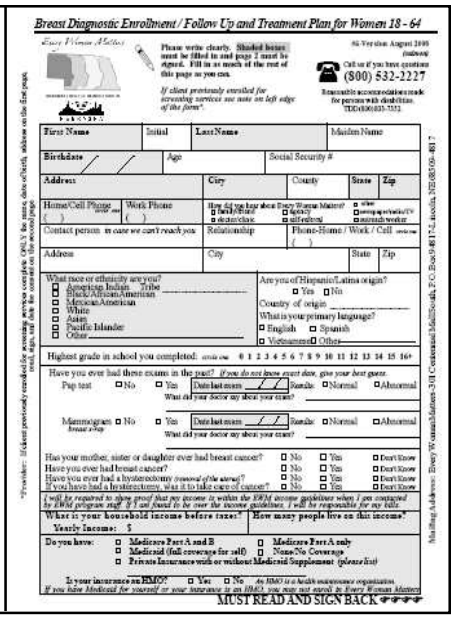
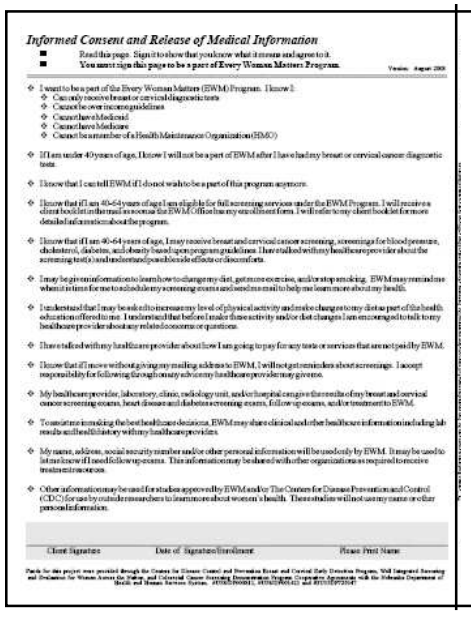


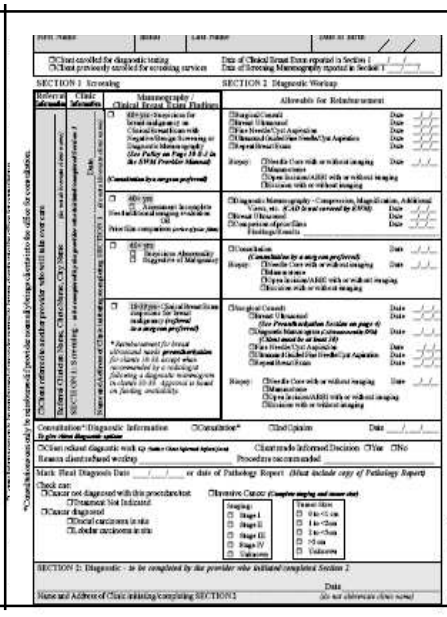
Breast Diagnostic Enrollment / Follow Up and Treatment Plan for Women 18 - 64

Client completes

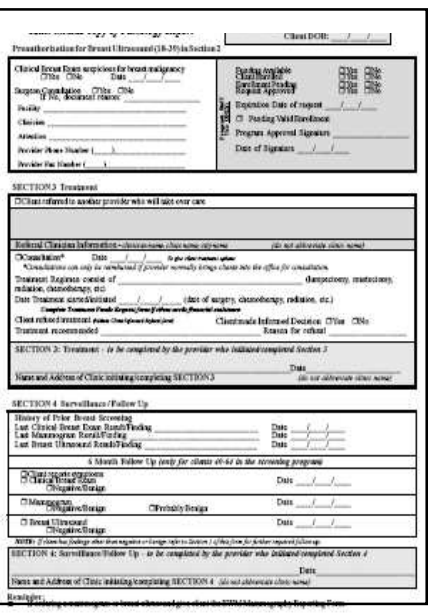


Informed Consent and Release of Medical Information

Client completes



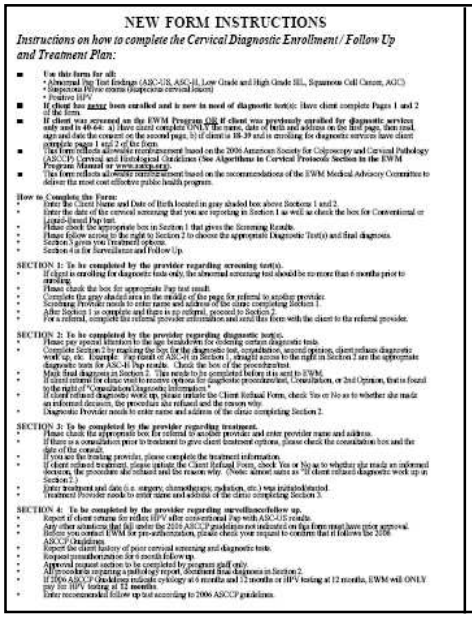
Provider completes



Provider completes

Cervical Diagnostic Enrollment/Follow Up and Treatment Form (blue)

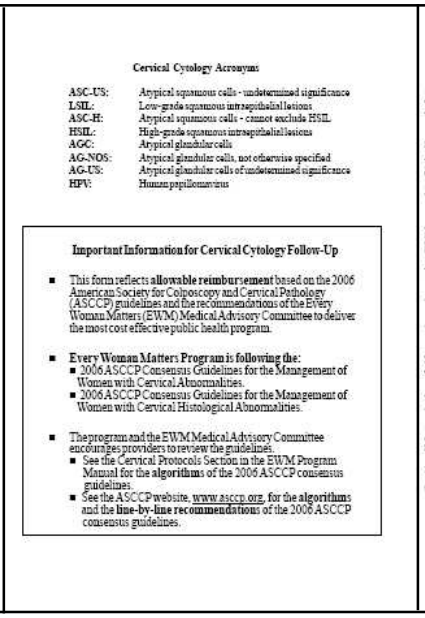
- 11x25 (6 page fold out)
- Page 1 - Enrollment
- Page 2 - Informed Consent
- Page 3/4 - Documents the client's medical necessity for services
- Page 5 - Instructions for Clinic on how to use the form
- Page 6 - Cervical Acronyms and Important Information
- Purpose: 1. Used in the clinic to enroll a client when there is a need of diagnostic services after an abnormal cervical screening and to document short interval Pap test or consultation visit
  2. Completed after an abnormal screening Pap test. Also used when performing diagnostic procedures and/or referring for further evaluation, diagnostic procedure, or treatment.



NEW FORM INSTRUCTIONS

Instructions on how to complete the Cervical Diagnostic Enrollment / Follow Up and Treatment Plan:

Provider Instructions



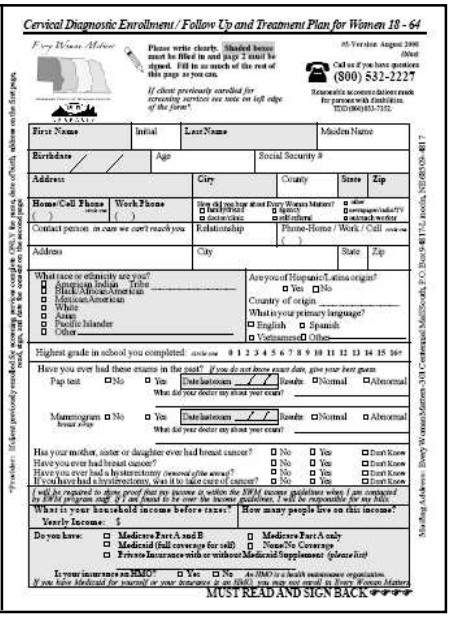
Cervical Cytology Acronyms

ASC-US:	Atypical squamous cells - undetermined significance
LSIL:	Low-grade squamous intraepithelial lesions
ASC-H:	Atypical squamous cells - cannot exclude HSIL
HSIL:	High-grade squamous intraepithelial lesions
AGC:	Atypical glandular cells
AG-NOS:	Atypical glandular cells, not otherwise specified
AG-US:	Atypical glandular cells of undetermined significance
HPV:	Human papillomavirus

Important Information for Cervical Cytology Follow-Up

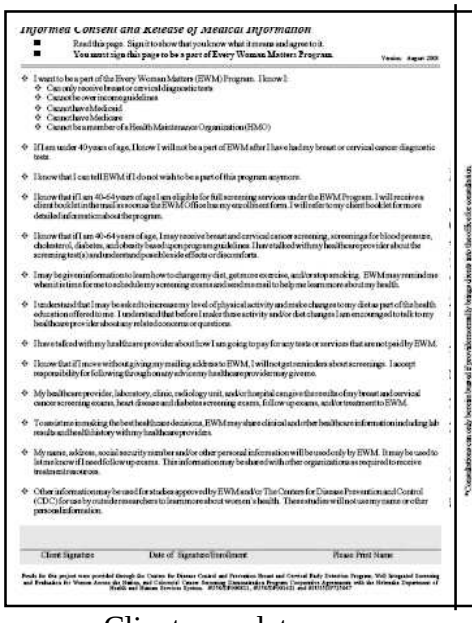
- This form reflects **allowable reimbursement** based on the 2006 American Society for Colposcopy and Cervical Pathology (ASCCP) guidelines and the recommendations of the Every Woman Matters (EWM) Medical Advisory Committee to deliver the most cost effective public health program.
- **Every Woman Matters Program is following the:**
  - 2006 ASCCP Consensus Guidelines for the Management of Women with Cervical Abnormalities.
  - 2006 ASCCP Consensus Guidelines for the Management of Women with Cervical Histological Abnormalities.
- The program and the EWM Medical Advisory Committee encourages providers to review the guidelines.
  - See the Cervical Protocols Section in the EWM Program Manual for the **algorithms** of the 2006 ASCCP consensus guidelines.
  - See the ASCCP website, www.asccp.org, for the **algorithms** and the **line-by-line recommendations** of the 2006 ASCCP consensus guidelines.

Provider education



Cervical Diagnostic Enrollment / Follow Up and Treatment Plan for Women 18 - 64

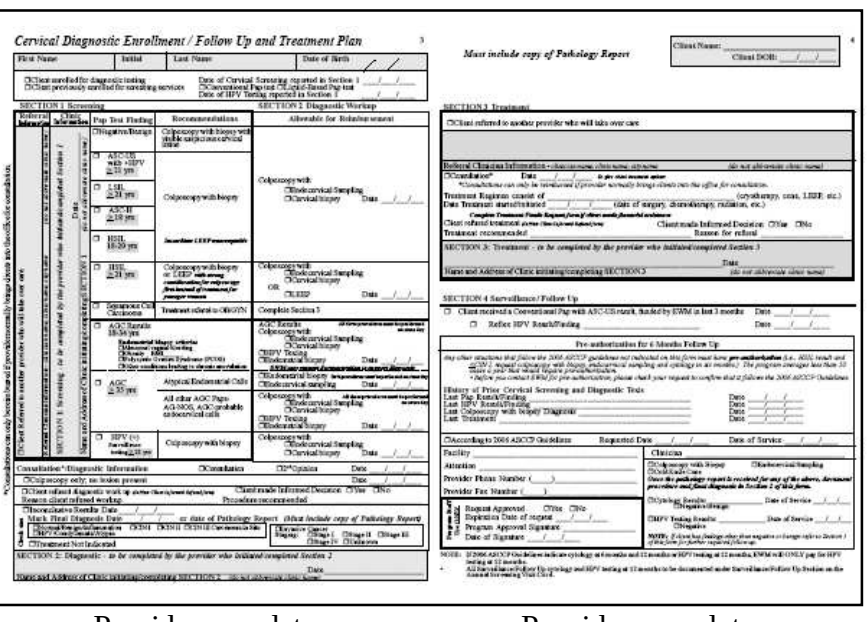
Client completes



Informed Consent and Release of Medical Information

Client Signature | Date of Signature/Enrollment | Please Print Name

Client completes



Cervical Diagnostic Enrollment / Follow Up and Treatment Plan

Must include copy of Pathology Report

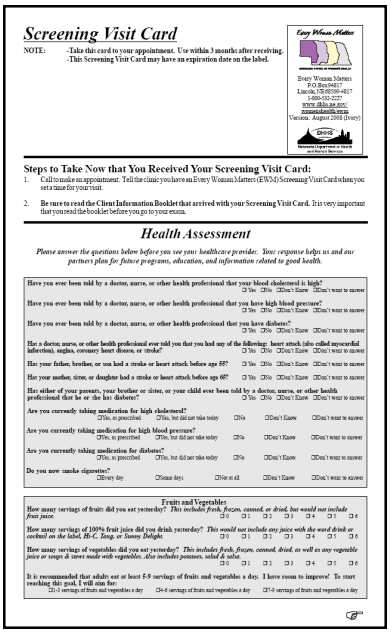
Provider completes

Provider completes

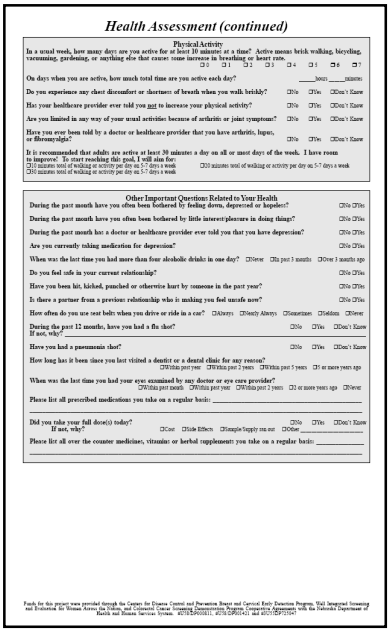
Screening Visit Card (ivory)

- 14x25 (5 page tri-fold)
- Page 1 - Client's Name, Instructions for Client, Health Assessment
- Page 2 - Health Assessment
- Page 3 - Documents the clients screening visit
- Page 4/5 - Heart Health Screening Results (tear out for client)
- Purpose: To document the client's screening visit

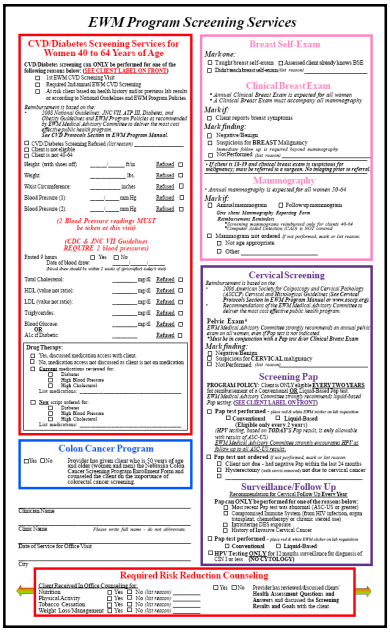
Client completes

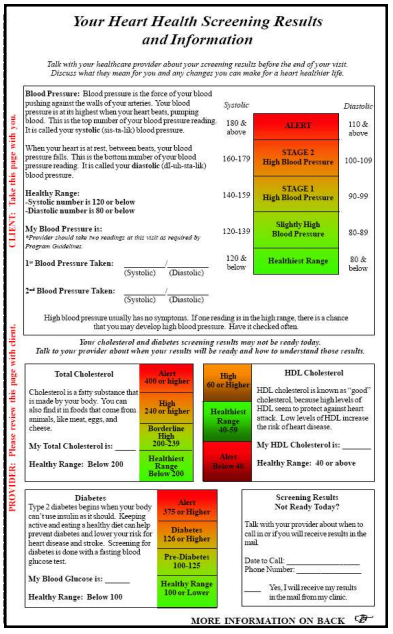


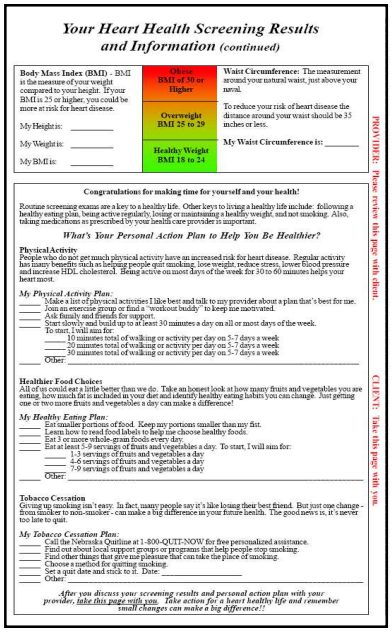
Client completes



Provider completes







Provider and Client completes together

Mammography Reporting Form

- 8 1/2 x 12 1/2 (3 part carbonless with an envelope attached at the bottom)
- Purpose: Used for ordering a screening mammogram, diagnostic mammogram or breast ultrasound. Clinic gives form to client to take to approved mammography/ultrasound facility.

Every Woman Matters Mammography Reporting Form

Client First Name ____ Initial ____ Last Name ____ Age ____

Date of Birth ____

Ordering Clinician's Remarks

Rt Lt

Mammography/Ultrasound Provider's Name ____

Date of Service ____

Mammography Findings

- Negative (NEG)
- Benign Findings (BB)
- Probably Benign (PBF) -Short Interval Follow Up Suggested
- Suspicious Abnormality (SAB)
- Highly Suggestive of Malignancy (MAL)
- Assessment is Incomplete (NAE)

Ultrasound Evaluation of Breast Mass

Date ____

Cystic mass ____

Solid mass ____

Negative US ____

Inconclusive ____

Recommendations of Radiologist

Diagnostic Mammography Views ____

Ultrasound ____

Fine Needle Aspiration ____

Biopsy ____

Repeat Mammogram in ____ Months Radiologist Signature ____

Out Patient Admissions / Patient Registration

Client Name ____

Date of Birth ____

Client

1. Make sure the mammography unit is participating in Every Woman Matters.
2. Tell the hospital or clinic you have this form when you set a time for your visit.
3. Give the bottom of this form to the person that checks you in.
4. Give the top of this form to the person that does your mammogram.
5. Pay nothing at your visit.

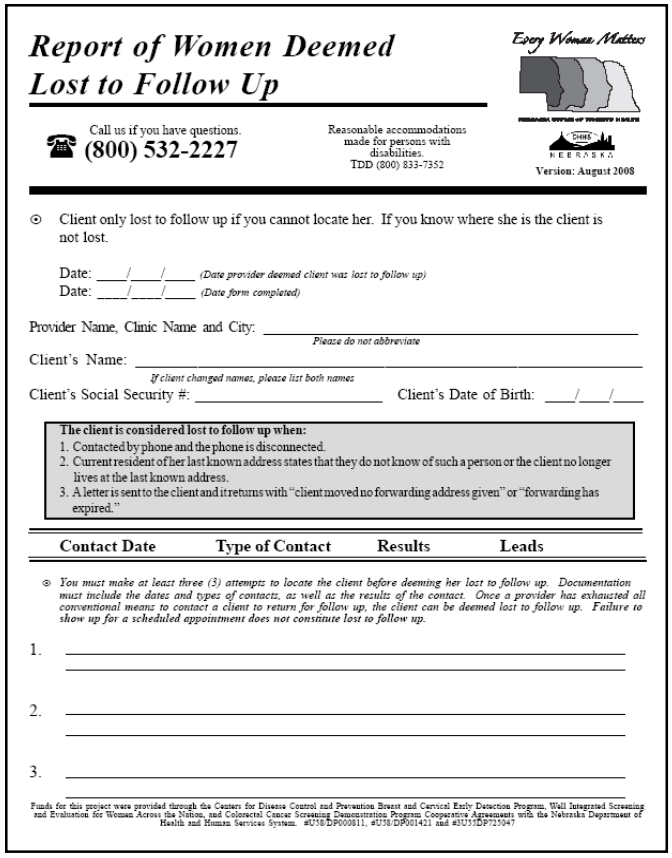
Registrar

1. Tear off the bottom of this form to track billing and identify client as an Every Woman Matters client.
2. Give the client the top half of the form to take to the mammography suite.
3. Do not take this form unless your facility is participating in the Every Woman Matters program.

Provider completes gray shaded area

Report of Women Deemed Lost to Follow Up

- 8 1/2 x 11
- Purpose: Used when a clinic has tried to contact a client three times for follow up and has had no response.



Report of Women Deemed Lost to Follow Up

Every Woman Matters

NEBRASKA

Call us if you have questions.
(800) 532-2227

Reasonable accommodations made for persons with disabilities.
TDD (800) 833-7352

Version: August 2008

⊙ Client only lost to follow up if you cannot locate her. If you know where she is the client is not lost.

Date: ____/____/____ *(Date provider deemed client was lost to follow up)*
Date: ____/____/____ *(Date form completed)*

Provider Name, Clinic Name and City: _____
Please do not abbreviate

Client's Name: _____
If client changed names, please list both names

Client's Social Security #: _____ Client's Date of Birth: ____/____/____

The client is considered lost to follow up when:
1. Contacted by phone and the phone is disconnected.
2. Current resident of her last known address states that they do not know of such a person or the client no longer lives at the last known address.
3. A letter is sent to the client and it returns with "client moved no forwarding address given" or "forwarding has expired."

Contact Date	Type of Contact	Results	Leads

⊙ *You must make at least three (3) attempts to locate the client before deeming her lost to follow up. Documentation must include the dates and types of contacts, as well as the results of the contact. Once a provider has exhausted all conventional means to contact a client to return for follow up, the client can be deemed lost to follow up. Failure to show up for a scheduled appointment does not constitute lost to follow up.*

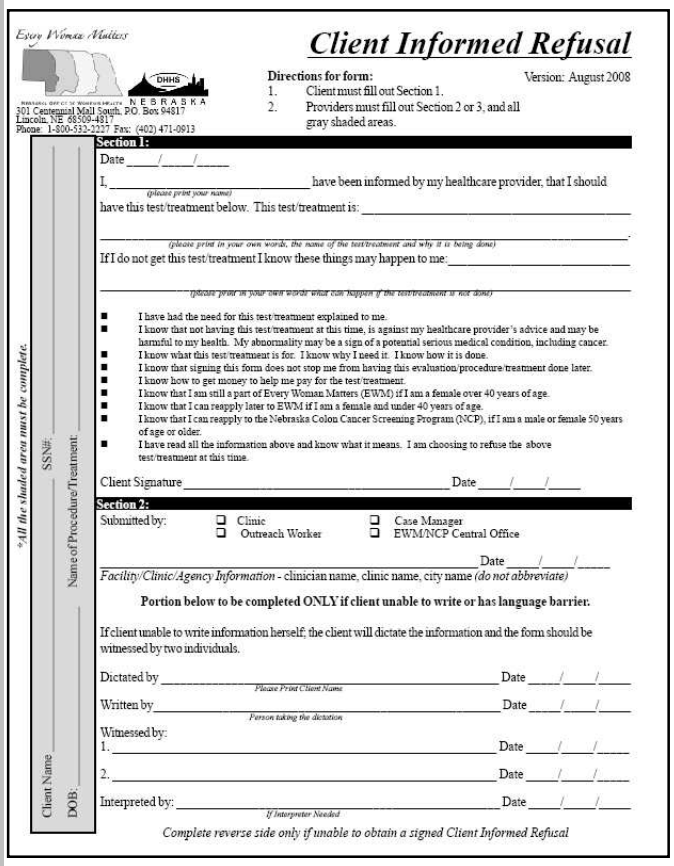
1. _____
2. _____
3. _____

Funds for this project were provided through the Centers for Disease Control and Prevention Breast and Cervical Early Detection Program, Well Integrated Screening and Evaluation for Women Across the Nation, and Colorectal Cancer Screening Demonstration Program Cooperative Agreements with the Nebraska Department of Health and Human Services System. #U58/DP000811, #U58/DP001421 and #5U55DP72047

Client Informed Refusal

- 8 1/2 x 11 (black 4 part carbonless)
- Purpose: If a client refuses services, she must sign this form, indicating that she understands the risks of refusing.

Client completes Section 1



Every Woman Matters

NEBRASKA

301 Centennial Mall South, P.O. Box 94817
Lincoln, NE 68509-4817
Phone: 1-800-532-2227 Fax: (402) 471-0913

Client Informed Refusal

Version: August 2008

Directions for form:
1. Client must fill out Section 1.
2. Providers must fill out Section 2 or 3, and all gray shaded areas.

**All the shaded area must be complete.*

Client Name _____ DOB: _____ SSN#: _____ Name of Procedure/Treatment: _____

Section 1:

Date ____/____/____

I, _____ have been informed by my healthcare provider, that I should have this test/treatment below. This test/treatment is: _____

(please print your name)

_____.

(please print in your own words, the name of the test/treatment and why it is being done)

If I do not get this test/treatment I know these things may happen to me: _____

_____

(please print in your own words what can happen if the test/treatment is not done)

- I have had the need for this test/treatment explained to me.
- I know that not having this test/treatment at this time, is against my healthcare provider's advice and may be harmful to my health. My abnormality may be a sign of a potential serious medical condition, including cancer.
- I know what this test/treatment is for. I know why I need it. I know how it is done.
- I know that signing this form does not stop me from having this evaluation/procedure/treatment done later.
- I know how to get money to help me pay for the test/treatment.
- I know that I am still a part of Every Woman Matters (EWM) if I am a female over 40 years of age.
- I know that I can reapply later to EWM if I am a female and under 40 years of age.
- I know that I can reapply to the Nebraska Colon Cancer Screening Program (NCP), if I am a male or female 50 years of age or older.
- I have read all the information above and know what it means. I am choosing to refuse the above test/treatment at this time.

Client Signature _____ Date ____/____/____

Section 2:

Submitted by: ❑ Clinic ❑ Outreach Worker ❑ Case Manager ❑ EWM/NCP Central Office

_____ Date ____/____/____

Facility/Clinic/Agency Information - clinician name, clinic name, city name *(do not abbreviate)*

Portion below to be completed ONLY if client unable to write or has language barrier.

If client unable to write information herself, the client will dictate the information and the form should be witnessed by two individuals.

Dictated by _____ Date ____/____/____

Please Print Client Name

Written by _____ Date ____/____/____

Person taking the dictation

Witnessed by:

1. _____ Date ____/____/____

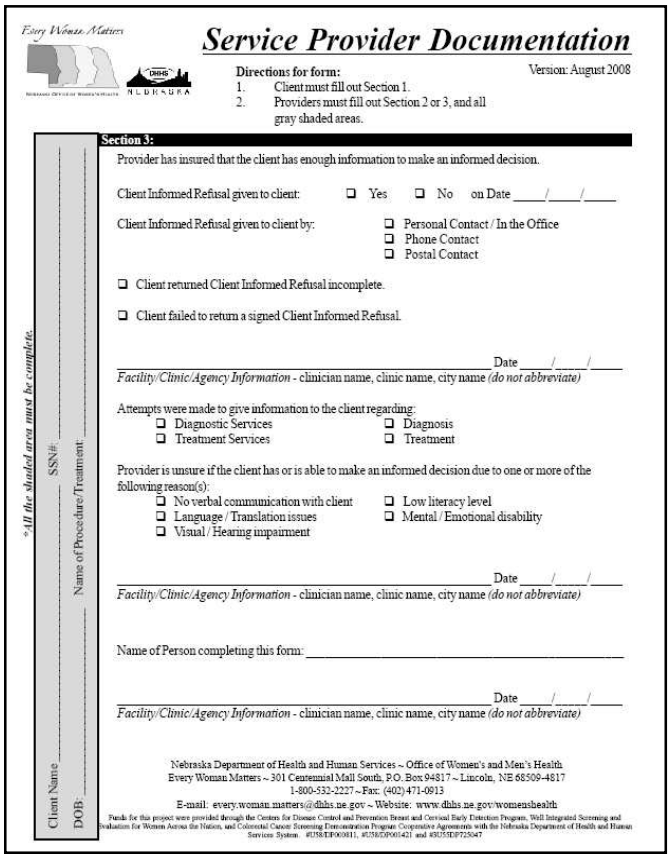
2. _____ Date ____/____/____

Interpreted by: _____ Date ____/____/____

If Interpreter Needed

Complete reverse side only if unable to obtain a signed Client Informed Refusal

Provider completes Section 2



Every Woman Matters

NEBRASKA

Service Provider Documentation

Version: August 2008

Directions for form:
1. Client must fill out Section 1.
2. Providers must fill out Section 2 or 3, and all gray shaded areas.

**All the shaded area must be complete.*

Client Name _____ DOB: _____ SSN#: _____ Name of Procedure/Treatment: _____

Section 3:

Provider has insured that the client has enough information to make an informed decision.

Client Informed Refusal given to client: ❑ Yes ❑ No on Date ____/____/____

Client Informed Refusal given to client by:
- ❑ Personal Contact / In the Office
- ❑ Phone Contact
- ❑ Postal Contact

❑ Client returned Client Informed Refusal incomplete.

❑ Client failed to return a signed Client Informed Refusal.

_____ Date ____/____/____

Facility/Clinic/Agency Information - clinician name, clinic name, city name *(do not abbreviate)*

Attempts were made to give information to the client regarding:
- ❑ Diagnostic Services
- ❑ Diagnosis
- ❑ Treatment Services
- ❑ Treatment

Provider is unsure if the client has or is able to make an informed decision due to one or more of the following reason(s):
- ❑ No verbal communication with client
- ❑ Low literacy level
- ❑ Language / Translation issues
- ❑ Mental / Emotional disability
- ❑ Visual / Hearing impairment

_____ Date ____/____/____

Facility/Clinic/Agency Information - clinician name, clinic name, city name *(do not abbreviate)*

Name of Person completing this form: _____

_____ Date ____/____/____

Facility/Clinic/Agency Information - clinician name, clinic name, city name *(do not abbreviate)*

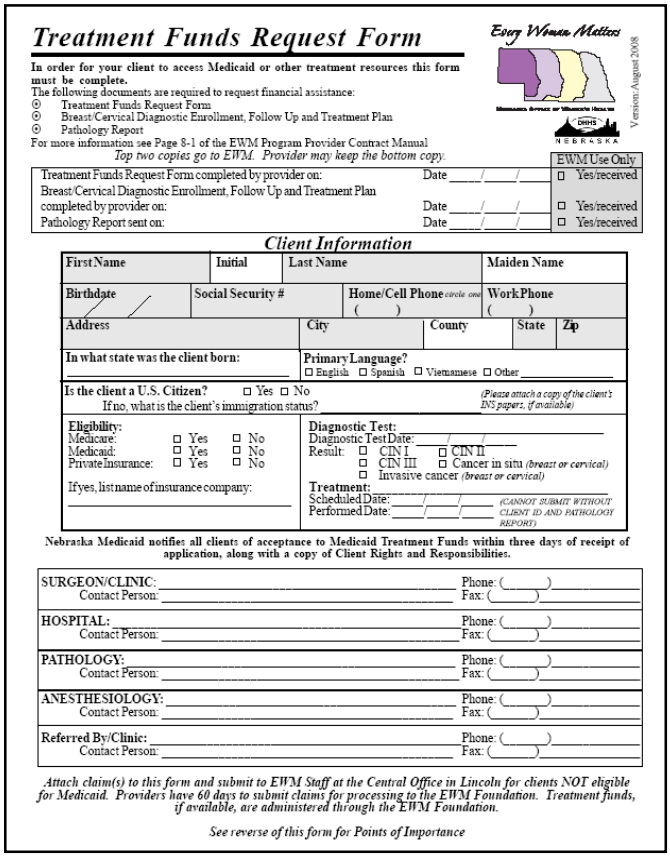
Nebraska Department of Health and Human Services ~ Office of Women's and Men's Health
Every Woman Matters ~ 301 Centennial Mall South, P.O. Box 94817 ~ Lincoln, NE 68509-4817
1-800-532-2227 ~ Fax: (402) 471-0913
E-mail: every.woman.matters@dhhs.ne.gov ~ Website: www.dhhs.ne.gov/womenshealth

Funds for this project were provided through the Centers for Disease Control and Prevention Breast and Cervical Early Detection Program, Well Integrated Screening and Evaluation for Women Across the Nation, and Colorectal Cancer Screening Demonstration Program Cooperative Agreements with the Nebraska Department of Health and Human Services System. #U58/DP000811, #U58/DP001421 and #U55/DP725047

Provider completes Section 3

Treatment Funds Request Form

- 8 1/2 x 11
- Purpose: Completed once a client has been diagnosed with cancer or precancer of the breast or cervix. In order for the client to access Medicaid or other treatment resources this form needs to be completed.



Treatment Funds Request Form

Every Woman Matters

Version: August 2008

In order for your client to access Medicaid or other treatment resources this form must be complete.
The following documents are required to request financial assistance:
- Treatment Funds Request Form
- Breast/Cervical Diagnostic Enrollment, Follow Up and Treatment Plan
- Pathology Report

For more information see Page 8-1 of the EWM Program Provider Contract Manual

Top two copies go to EWM. Provider may keep the bottom copy.

		EWM Use Only
Treatment Funds Request Form completed by provider on:	Date ____/____/____	☐ Yes/received
Breast/Cervical Diagnostic Enrollment, Follow Up and Treatment Plan completed by provider on:	Date ____/____/____	☐ Yes/received
Pathology Report sent on:	Date ____/____/____	☐ Yes/received

Client Information

First Name	Initial	Last Name	Maiden Name
Birthdate	Social Security #	Home/Cell Phone *circle one* ( )	Work Phone ( )
Address	City	County	State / Zip
In what state was the client born:	Primary Language? ☐ English ☐ Spanish ☐ Vietnamese ☐ Other		
Is the client a U.S. Citizen? ☐ Yes ☐ No If no, what is the client's immigration status? *(Please attach a copy of the client's INS papers, if available)*			
Eligibility: Medicare: ☐ Yes ☐ No; Medicaid: ☐ Yes ☐ No; Private Insurance: ☐ Yes ☐ No. If yes, list name of insurance company:	**Diagnostic Test:** Diagnostic Test Date: ____/____/____ Result: ☐ CIN I ☐ CIN II ☐ CIN III ☐ Cancer in situ *(breast or cervical)* ☐ Invasive cancer *(breast or cervical)* **Treatment:** Scheduled Date: ____/____/____ Performed Date: ____/____/____ *(CANNOT SUBMIT WITHOUT CLIENT ID AND PATHOLOGY REPORT)*		

Nebraska Medicaid notifies all clients of acceptance to Medicaid Treatment Funds within three days of receipt of application, along with a copy of Client Rights and Responsibilities.

SURGEON/CLINIC: _____ Contact Person: _____	Phone: (_____)_____ Fax: (_____)_____
HOSPITAL: _____ Contact Person: _____	Phone: (_____)_____ Fax: (_____)_____
PATHOLOGY: _____ Contact Person: _____	Phone: (_____)_____ Fax: (_____)_____
ANESTHESIOLOGY: _____ Contact Person: _____	Phone: (_____)_____ Fax: (_____)_____
Referred By/Clinic: _____ Contact Person: _____	Phone: (_____)_____ Fax: (_____)_____

Attach claim(s) to this form and submit to EWM Staff at the Central Office in Lincoln for clients NOT eligible for Medicaid. Providers have 60 days to submit claims for processing to the EWM Foundation. Treatment funds, if available, are administered through the EWM Foundation.

See reverse of this form for Points of Importance

Claim Status Form

- 8 1/2 x 11
- Purpose: Completed by clinic and faxed to EWM Central Office to inquire about claim status.

CLAIM STATUS FORM

Every Woman Matters

NEBRASKA OFFICE OF WOMEN'S HEALTH

State of Nebraska, Department of Health and Human Services
Office of Women's Health
Every Woman Matters Program
301 Centennial Mall South
PO Box 94817
Lincoln, NE 68509-4817
PHONE: 1-800-532-2227 or 402-471-0929
FAX: 402-471-0913

This transmission may include protected health information, under the standards established per the Health Insurance Portability and Accountability Act of 1996, and Neb. Rev. Stat., §68-313. If this information has been received in error, the recipient is directed to return to sender or destroy the information and notify this office of the error immediately. Failure to do so may lead to civil or criminal penalties.

The document will be reviewed and returned within 2 working days.

PROVIDER NAME:
Name of Contact Person:
Telephone Number:
Fax Number:

PROVIDERS MUST COMPLETE FIRST 5 COLUMNS …USE A SEPARATE LINE FOR EACH CPT CODE

(1) Patient Name	(2) DOB	(3) DOS	(4) CPT	(5) Billing Amount	(EWM to complete this Section) COMMENTS

- PLEASE REVIEW your most recent Billing Authorization Report before sending Claim Status Requests.
- EWM staff will not review claims that are less than 60 days from date of service.
- PLEASE allow 45 days filing date so claims can process through 1 billing cycle before requesting review.
- If a PAID date is noted in the comment column, this is the date Authorized by EWM staff. Please allow 2 weeks for payment to issue.

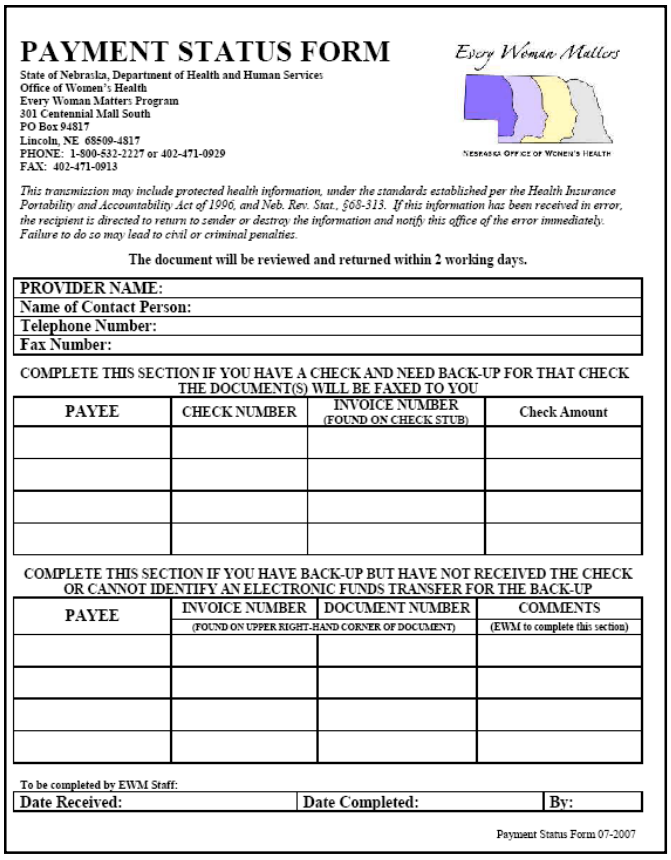
To be completed by EWM Staff:

Date Received:	Date Completed:	By:

Claim Status Form Version 09-2008

Payment Status Form

- 8 1/2 x 11
- Purpose: Completed by clinic and faxed to EWM Central Office to inquire about payment status.



PAYMENT STATUS FORM

Every Woman Matters

NEBRASKA OFFICE OF WOMEN'S HEALTH

State of Nebraska, Department of Health and Human Services
Office of Women's Health
Every Woman Matters Program
301 Centennial Mall South
PO Box 94817
Lincoln, NE 68509-4817
PHONE: 1-800-532-2227 or 402-471-0929
FAX: 402-471-0913

This transmission may include protected health information, under the standards established per the Health Insurance Portability and Accountability Act of 1996, and Neb. Rev. Stat., §68-313. If this information has been received in error, the recipient is directed to return to sender or destroy the information and notify this office of the error immediately. Failure to do so may lead to civil or criminal penalties.

The document will be reviewed and returned within 2 working days.

PROVIDER NAME:	
Name of Contact Person:	
Telephone Number:	
Fax Number:	

COMPLETE THIS SECTION IF YOU HAVE A CHECK AND NEED BACK-UP FOR THAT CHECK
THE DOCUMENT(S) WILL BE FAXED TO YOU

PAYEE	CHECK NUMBER	INVOICE NUMBER (FOUND ON CHECK STUB)	Check Amount

COMPLETE THIS SECTION IF YOU HAVE BACK-UP BUT HAVE NOT RECEIVED THE CHECK
OR CANNOT IDENTIFY AN ELECTRONIC FUNDS TRANSFER FOR THE BACK-UP

PAYEE	INVOICE NUMBER (FOUND ON UPPER RIGHT-HAND CORNER OF DOCUMENT)	DOCUMENT NUMBER	COMMENTS (EWM to complete this section)

To be completed by EWM Staff:

Date Received:	Date Completed:	By:

Payment Status Form 07-2007